

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>49990</p> <p>Based on facility record review, staff interview, and policy review, the facility failed to provide three of three sampled residents the required properly filled out forms for Medicare Liability Notices and Beneficiary Appeals within 48 hours of when skilled services ending (Resident # 26, # 204, # 205). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>Record review of Resident #26 revealed last day of skilled coverage was dated 10/29/24. The facility issued a Notice of Medicare Non-Coverage (NOMNC) Centers for Medicare Services (CMS) Form #10123 and the form was signed before the 48 hour required window. However, the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) CMS form #10055 was not present. Record review showed Resident #26 was a current resident of the facility at the time of the survey.</p> <p>Record review of Resident #204 revealed last day of skilled coverage was dated 06/27/24. The facility issued a NOMNC CMS Form #10123 that was signed by the power of attorney (POA) on 06/24/24, well within the 48-hour required window. However, SNFABN CMS form #10055 was not present. Record review showed Resident #204 remained a resident of the facility after the NOMNC was provided.</p> <p>Record review of Resident #205 revealed last day of skilled coverage was dated 07/03/24. The facility issued a NOMNC CMS Form #10123 and SNFABN CMS form #10055 that was signed by the POA on 07/01/24, within the 48-hour required window. The forms did not contain the required disclosure of the cost of services should the resident have decided to pay out of pocket.</p> <p>In an interview on 11/20/24 at 09:54 AM with the Regional Director of Operations and the [NAME] President of Clinical Reimbursement, they were unsure as to why SNFABNs had not been issued for Resident #26 and Resident #204. The [NAME] President of Clinical Reimbursement confirmed that Resident #205 should have had the cost of services disclosed on the SNFABN.</p> <p>In an interview on 11/20/24 at 10:11 AM with the [NAME] President of Clinical Reimbursement, she confirmed both Resident #26 and Resident #204 should have been provided SNFABNs.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility provided document titled Medicare Advanced Beneficiary Notice - Policy Statement, under section 1, subsection B, reads SNFABNs are provided if the beneficiary intends to continue services and the Skilled Nursing Facility (SNF) believes the services may not be covered under Medicare.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817</p> <p>Based on record review, facility investigation file review, resident and staff interviews, and facility policy review, the facility failed to ensure all allegations of abuse including allegations of staff to resident verbal threats and rough treatment, and inappropriate touching of a resident's buttocks by Staff A were reported timely to the facility administration for three of four residents reviewed for abuse (Resident #10, #38, and #28). The incident of alleged abuse that occurred on 8/8/24 was not reported to the Department of Inspections, and Appeals and Licensing (DIAL) until 8/30/24. The allegation of abuse on 10/21/24 was not reported to DIAL until 10/23/24. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents. There was evidence that a serious adverse outcome was likely to occur due to the facility failed to protect residents from allegation of abuse and allowed staff to continue to work. This placed all residents at risk for abuse. The facility needed to take immediate action to ensure that all abuse allegations are reported in a timely manner.</p> <p>The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had diagnoses of cerebral vascular disease (CVA) (stroke), hemiplegia, anxiety disorder, and chronic pain. The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) of 13 indicating intact cognition. The MDS documented the resident had no behaviors, able to express her wants, understood others and made herself understood. The resident had dependence on staff for dressing, hygiene, and bed mobility.</p> <p>Resident #10's Care Plan revised 6/17/24 revealed the resident had limitations in her ability to perform activities of daily living (ADLs) related to contractures, hemiplegia, and pain. The resident also presented with fear/anxiety related to lack of understanding of treatments. The Care Plan recorded the resident made false allegations at times (initiated 5/21/18). The care plan directed staff to implement measures to reduce fear and anxiety (initiated 11/10/17), notify the charge nurse of any allegations made right away (added to care plan 5/21/18), explain all procedures to the resident before starting and allow the resident time to adjust to changes (added 8/14/24), re-approach the resident and have alternative staff assist the resident if needed (added 8/14/24).</p> <p>The facility's investigation file contained the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Incident Summary: Resident #10 admitted to the facility on [DATE]. Resident requires assistance of two for bed mobility and ADL care, assistance of one for check and change, and assistance of two for transfers. BIMS on 6/7/24 was 13. On 8/8/24, sometime between 8 PM- 10 PM, the nurse was notified Resident #10 experienced pain after completion of pericare. Resident #10 stated she felt the aide was rough with her and as they were doing pericare, the aide went deep in her buttock, and she felt like she was bruised. The nurse assessed the resident's pericare with no signs of bruising or bleeding observed. The resident denied pain. The nurse immediately provided pericare education to the CNA's (certified nursing assistant) on the evening shift. The Director of Nursing (DON) and Administrator completed an interview with the resident who stated she had no concerns about pericare or the care she was receiving. Interviews also completed with staff who were in the room. The CNA performing the care stated that the bowel movement (BM) was dried on the resident's buttock and when she attempted to wipe it off, the resident said ouch. The other CNA in the room stated she was assisting the other resident in the room when she heard Resident #10 say ouch. She heard the CNA say I am sorry and continued with the pericare.</p> <p>The DON completed competencies with Staff A related to pericare, with no concerns.</p> <p>Skin assessments were completed with no concerns notes. The resident denied pain.</p> <p>Administrator initiated staff re-education on abuse and neglect standards and reporting completed by 9/6/24, and ongoing education provided through annual in-service. Residents with BIMS 12 or higher were interviewed and asked if they had been mistreated and if they felt safe. No concerns were noted.</p> <p>Social Services will follow up with Resident # 10 to assure she had no further concerns and felt safe.</p> <p>b. A written statement by Staff A, CNA, dated 8/8/24, revealed on 8/8/24, Staff O and I were doing Resident #10's care. Resident #10 was like you are hurting me. I told her you have dry BM and I have to clean you up. The resident said ok, can you use the cream after you are done cleaning me? I said yes and I did but she (Resident #10) was so abusive. Resident #10 told the nurse. The nurses and the other CNA on that day checked her to see if she was hurt. There were no marks on her. I took a snack to the resident and forgot to open it. Because of that she (Resident #10) called me a black niga. I reported it to the nurse.</p> <p>c. A typed statement by Staff G, Licensed Practical Nurse (LPN), dated 8/31/24 revealed the CNA told me a resident was complaining of pain after pericare. I went to get the other nurse on duty and went into the resident's room to assess the situation. I evaluated the resident's skin and her pain but noted no concerns. I spoke with the CNAs about pericare. Later that evening, the CNA told me that the same resident called her a racial name. I went to talk to the resident and she stated it was because the aide was rough with her during pericare. Again, I asked the resident about pain and she denied having pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. A typed statement by Staff O, CNA, dated 8/31/24 revealed I was in the room with Staff A and Resident #10 while I performed cares on the other resident (in the room). I heard Resident #10 say ouch during pericare. I stopped what I was doing and I heard Staff A apologize to Resident #10 while pericare completed. I asked Staff A why Resident #10 said ouch. Staff A said she was wiping the BM. When I finished my cares I went and told the nurse immediately. The nurse went into the room to talk to the resident. After that, the nurse talked to me and the other CNA's about pericare.</p> <p>e. An undated written statement by the former Administrator and DON revealed when interviewing the resident, the resident denied any roughness during pericare and stated she had no concerns with the pericare that was provided. She denied using any racial slur. She stated she felt safe and doesn't have any further concerns.</p> <p>f. Staff meeting dated 8/3/24 about abuse and neglect presented by the former Administrator.</p> <p>A Progress Note documented by Staff G, LPN, on 8/9/24 at 2:42 AM revealed the resident reported to staff that a caregiver was rough with her. Resident stated that as staff were doing pericare, the aide went deep in her buttock and she felt like she was bruised from staff cleaning her. This nurse called other staff on duty to do a proper assessment focusing on the periarea. No bruising or bleeding noted. The resident denied pain at the time of assessment. Staff reported to this writer that resident was very mean to her while doing pericare with another staff. As staff returned to pass snacks, the resident called staff attention by using an N word You black Nigger, open my snack. Staff reported that she opened the snack and decided to let this writer know.</p> <p>During an interview 11/21/24 at 12:05 PM, Staff G, LPN, reported she had worked at the facility since the beginning of 2024, and worked the 6 PM - 6 AM shift. Staff G reported Resident #10 could be very needy, and constantly called for things, even though the nurses went in to see what she needed. The resident sometimes refused things. Staff G reported she had received mandatory reporter training. Staff G stated she would notify her supervisor or the Administrator immediately if she had a concern about abuse. On the day Resident #10 reported a concern regarding her cares, Resident #10 told Staff G a staff person was being mean to her since the staff CNA's came in at 2:00 PM that day. The concern had not been reported to Staff G until around 8 PM when staff passed snacks (to the resident). Staff G reported she went and talked to the resident. She called the nurse from the opposite hall and did a full assessment with the other nurse present. She did not see any bruising. Resident #10 said her bottom was hurting. Staff G stated she had not witnessed Staff A being mean or rough with a resident at any time. Staff G acknowledged she did not report the incident to her supervisor or the Administrator. It slipped her mind to call the Administrator or DON right away. She wrote a note and put it in the mailbox for the Administrator and placed a copy of what she wrote in the unit manager's mailbox that night. The DON, Administrator, or Unit Manager did not call her until 8/26. The DON asked her about the incident and why she did not call right away. The Administrator at that time also called her and asked about the incident. Staff G apologized to the Administrator and said there was a lot going on that night, and she just didn't call.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/21/24 at 1:04 PM, Staff A, CNA, reported she had worked at the facility for 4 months. Staff A reported she received one week of orientation at the facility. Orientation entailed learning about the residents, what the residents needed, and how to take care of them. Staff A reported she had a problem with Resident #10 because the resident didn't like or want her. Resident #10 only wanted certain staff taking care of her. Staff A reported Resident #10 was always abusive to her. She let the nurse know about it. Staff A reported she took snacks to Resident #10 that day (8/8/24). Resident #10 told her she didn't bring her crackers and called Staff A a black niger. Staff A reported this made her cry and she told the nurse. Staff also stated some staff didn't like her but she came to work and did her job. Some staff took 5-6 breaks a shift or took an hour break, and then she didn't get a break, and she was the only person left on the unit to do the work. She reported to the Administrator the other CNA took an hour break and Staff A didn't get a break. This was reported the week just prior to her getting suspended when she was accused of being rough with Resident #10.</p> <p>During an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON acknowledged she had observed Staff A when she did a pericare audit otherwise she had not seen Staff A perform cares on Resident #10. The Unit Manager reported she got a statement from Staff A. The DON helped with the investigation regarding Resident #10 when the incident was reported. Resident #10 had reported staff wiped her too hard. The nurse on duty talked to Resident #10. Resident #10 said she wanted staff to wipe her more gently. The DON reported she did an audit and went over the pericare competency with Staff A. Resident #10 stated at the time she had no concerns with Staff A taking care of her. The DON stated she didn't know the exact date when the incident was reported to the State. Education provided to staff on abuse and neglect, and any concerns needed to be reported right away to the Administrator or DON. The DON reported staff educated about abuse at the time of hire and as needed.</p> <p>During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported when she became aware of a concern, she talked to Resident #10 and asked her to explain what happened. Resident #10 told her she didn't like how staff rolled her and thought staff wiped her too hard. The unit manager thought the resident had BM stuck to her bottom and perhaps some pubic hair got pulled as staff cleaned the area.</p> <p>In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she had taken the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. On the day, Resident #10 voiced concern about a CNA doing cares, Staff J stated she was not working on that side of the building, but the nurse working the North Hall came and got her and told her Resident #10 had told her Staff A was rough with her when the CNA performed pericare. Staff J and Staff G performed a skin assessment on the resident. They didn't observe any scratches, redness, or bruising. The incident took place about 2-3 months ago.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview 11/25/24 at 12:41 PM, the interim Administrator reported she had worked at the facility from 7/2024 to the end of 9/2024. The interim Administrator reported toward the end on 8/2024, she saw a progress note about an alleged abuse that happened 2-3 weeks prior to that. She reported to DIAL, notified the police and the resident's physician, and started an investigation. Resident #10 had a history of false allegations. It was listed on her care plan. The interim Administrator confirmed Staff A never told her a resident called her a derogatory name or N word until she was investigating this incident.</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation-Prevention Program revised 4/2021 residents had the right to be free from abuse, neglect, and exploitation. This includes freedom from corporal punishment, verbal, mental, and sexual or physical abuse. Abuse allegations reported and investigated within timeframes required by federal requirements.</p> <p>A facility's Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigation Policy revised 9/2022 revealed all reports of resident abuse reported to local, state and federal agencies as required by current regulations. Any suspicion of resident abuse must be reported immediately to the Administrator and other officials according to state laws. The Administrator or individual making the abuse allegation must report suspicion of abuse to the state licensing/certification agency responsible for surveying and licensing the facility immediately within two hours of an allegation involving abuse or serious bodily injury or within 24 hours of an allegation that does not involve abuse</p> <p>2. The MDS assessment dated [DATE] revealed Resident #38 had diagnoses of stroke, hemiplegia, aphasia, and schizophrenia. The resident had impaired short term and long-term memory but able to recall the current season, location of room, and staff names and faces. The MDS indicated the resident had no behaviors. The MDS recorded the resident had dependence on staff for dressing and hygiene, and required substantial to maximum assistance for bed mobility.</p> <p>The Care Plan revised 2/29/24 revealed Resident #38 had a CVA affecting the right side of her body and the ability to speak. The resident had limited range of motion due to contractures to her arms and legs. The resident had impaired cognitive function, communications and impaired thought processes and difficulty communicating and understanding others. The Care Plan directed staff to provide assistance of two for bed mobility and dressing, cue as needed, and ask yes/no questions in order to determine the resident's needs.</p> <p>The Facility's Investigation File revealed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. A summary of events: On Wednesday, 10/23/24 at 2:17 PM, Staff B, CNA, came to the DON and reported an allegation of abuse. Staff B reported Staff A was rough and used more than necessary strength to turn and reposition a resident when she provided cares on 10/21/24 evening. Staff B stated Staff A said to Resident #38 during care If you punch me, I'll punch you and if you pinch me, I'll pinch you. DON educated Staff B that suspected abuse and neglect must be reported immediately to ensure the resident's safety. Staff B was suspended and immediately received education about reporting abuse and neglect both suspected and actual. Staff B returned to work on 10/24/24 after abuse education provided. An investigation was initiated immediately. The DON interviewed Resident #38. Yes and No questions asked due to the residents communication deficits. The resident nodded her head yes when asked if someone was rough with her on Monday night and if she felt safe in the facility. Resident #38 then refused further questioning. The alleged incident was reported to DIAL. Physician, police, and POA notified on 10/23/24. The Unit Manager completed a skin assessment on Resident #38 on 10/23/24. No new skin concerns noted. No pain concerns noted. The unit manager obtained a statement from Staff A. Staff A was immediately suspended pending investigation. Staff A stated she provided care to Resident #38 prior to and after supper. She stated Staff B assisted in lift transfer into chair prior to supper and out of chair after supper. Staff A stated no concerns were voiced during or after cares. Residents with BIMS 12 or higher were interviewed, and no concerns voiced regarding mistreatment and they felt safe in the facility. Staff education provided on abuse, neglect and exploitation policy and timely reporting of abuse. Education regarding when, where, and who to report suspected, confirmed or alleged abuse.</p> <p>b. A written staff statement by Staff B, CNA, dated 10/23/24 revealed on Monday 10/21/24 while working with Staff A CNA, on the South Hall. We were getting Resident #38 up for dinner and Staff A appeared to use excessive force while turning Resident #38 to put the sling under her. Resident #38 yelled Hey! and began swinging her elbow at Staff A. Staff A told Resident #38 if you punch me, I will punch you, if you pinch me, I will pinch you. After we got the sling under Resident #38, we got her up into a chair and I told Staff A I'll finish up with her, you can go.</p> <p>c. A typed statement by the Unit Manager dated 10/23/24 revealed the unit manager spoke with Staff A, CNA, regarding reporting abuse. Staff A stated she had no issue with the resident. Staff A stated she had gotten the resident ready for supper by herself and asked for help with the hooyer (mechanical lift) transfer. Staff A stated Staff B helped her with the transfer. Staff A transferred the resident back to the room via wheelchair and assist of one after supper. Staff B assisted resident back to bed via the mechanical lift. Staff A stated the resident had no complaints with the transfer. Staff B helped her with evenings cares. Staff A stated she did the pericare and resident had no complaints of pain, discomfort or signs of fear.</p> <p>d. Staff H, CNA, was interviewed on 10/24/24 at 2:10 PM and stated there were no complaints from Resident #38 throughout the shift and she did not hear of anything else occurring throughout the shift.</p> <p>e. Staff I, CNA, was interviewed on 10/24/24 at 2:15 PM and stated there were no complaints from Resident #38 throughout the shift. She worked with Staff H on the North hall all night and she did not hear of anything else occurring throughout the shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. Staff J, LPN, was interviewed on 10/24/24 at 6:15 PM. Staff J stated there was nothing reported to her when she came on for her shift or throughout the rest of the evening shift. She was not told of any complaints from Resident #38 and stated she did not notice any behavior differences following administering her evening medications.</p> <p>An Incident Report dated 10/23/24 revealed a CNA came to the DON's office and reported on 10/21 around supper time another CNA was rough with the resident when repositioning the resident and made the statement If you punch me, I will punch you, if you pinch me, I will pinch you. Resident nodded yes that a staff member was rough with her and nodded no that she does not feel unsafe when asked about the event. Interviews completed with the staff and the resident involved. CNA suspended pending investigation and due to delay in reporting despite having received dependent adult abuse reporting education. Staff re-educated on needing to report any suspected and/or actual abuse and neglect immediately. No resident injuries observed at the time of the incident.</p> <p>In an interview on 11/20/24 at 1:24 PM, Resident # 38 stated yea when asked if staff treated her well. The resident denied staff had threatened to pinch or punch her, and no staff had been unkind or rough with her.</p> <p>In an interview on 11/20/24 at 2:47 PM, Staff B, CNA, reported she had worked at the facility since 9/2024 but had been a CNA for [AGE] years. She had mandatory reporter training prior to being hired at the facility. Staff B reported Resident # 38 didn't have any behaviors but could get a little tempermental. The resident was contracted and stiff on her right side, and she could be in a lot of pain. Staff B reported on the day of the incident, she went into the resident's room with Staff A, CNA, to get Resident #38 up for dinner. Resident #38 required assistance of two staff and a mechanical lift. When getting the resident up, she could exhibit being a little stiff from lying in bed. The resident threw her elbow up when Staff A moved the resident to pull the sling under her. Staff B reported whenever Resident #38 moved her right elbow up, it meant you're hurting me. Staff B thought Staff A turned the resident in an aggressive way. Staff A told the resident if you punch me, I will punch you, if you pinch me, I will pinch you. Staff B told Staff A we're not going to do that. Staff A and Staff B transferred Resident #38 from the bed to her wheelchair, and Staff B finished getting the resident dressed. Staff B told Staff A she would take care of Resident #38 the rest of the evening. Staff B stated she did not contact the DON or Administrator at the time to report the incident. She told the nurse that was working on that hall she would need her assistance with Resident #38 the rest of the evening. The nurse asked why and she told the nurse she was not comfortable with the way Staff A spoke with the resident. Staff B acknowledged she was not familiar with the process and what she needed to do when the incident happened. Staff B stated she spoke with the DON on 10/23 about what happened. The DON had her write a statement and then asked her to go home. She returned to the facility the next day. Staff B reported Staff A was also sent home on 10/23 but she doesn't know what happened to her after that. The DON gave her phone number and told her to call right away if this came up in the future, because she needed to report it right away. Staff B confirmed Staff A continued to work on the same hall with assigned residents on the evening of the alleged incident with Resident #38. Staff B reported Resident #38 did not seem to be in more pain than usual or appear more tearful or upset during the rest of the shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Staff B demonstrated with the surveyor how Resident #38 was in bed and how Staff A yanked on resident's arm to roll her. Staff A placed her hands on resident's upper arm and another hand on her leg to roll the resident onto her side to get the sling under her. When Staff A grabbed the resident's arm and yanked her, the resident's elbow went up and the resident yelled out. After they got the resident transferred into the wheelchair, Staff B told Staff A she (Staff B) would take care of the resident the rest of the evening.</p> <p>In an interview 11/20/24 at 4:17 PM, Staff K, Registered Nurse (RN) reported she had worked at the facility since 7/2024 as an agency nurse. She worked the 6 AM to 6 PM shift. Staff K stated she noticed Resident #38 had a behavior once while Staff K applied lotion to her feet and the resident almost kicked her. Sometimes the resident refused to [NAME] down or get changed. Staff K confirmed she oversaw staff when she worked. Staff are kind to the residents but sometimes the CNA laughed at the resident whenever a resident tried to express themselves, and it agitated the resident. Staff K stated she pulled staff aside and talked to the CNA and explains to them not to do that because it could agitate the resident and escalated the resident's behaviors. Staff K stated she didn't recall a time when a CNA came and asked her to help with Resident #38 the rest of the evening. There were times when she had to help the CNAs because the resident wouldn't let them put a sling under her. Staff K confirmed she had training for dependent adult abuse in the past year. Staff K reported if she witnessed staff being unkind or rough with a resident she would immediately separate the resident from staff, talk to the resident to see what happened, ensure the resident's safety, and let the Administrator know. Staff K acknowledged she had not received any hands on training or education about abuse while she worked at the facility as agency. Staff K reported if someone reported to her a staff person said to a resident, If you punch me, I will punch you, if you pinch me, I will pinch you, she would consider this a concern for abuse and she would report it immediately to the Administrator or DON right away. She is not aware of any staff person saying to a resident if you punch me, I will punch you. If you pinch me, I will pinch you. She doesn't recall any CNA asking her to help with Resident #38 during the rest of her shift in the past month because didn't feel comfortable with another CNA helping this resident.</p> <p>In an interview on 11/20/24 at 4:50 PM, Staff B confirmed she told Staff J, LPN, to help her with cares or things needed for Resident #38 on 10/21/24.</p> <p>Staff H, CNA, failed to respond back to voice and text messages sent on 11/21/24 at 9:26 AM by the surveyor.</p> <p>In an interview 11/21/24 at 9:30 AM, Staff I, CNA, reported she had worked at the facility since 9/2024. She works the 2-10 PM shift. Staff I reported she had computer-based training on abuse. Staff I stated she helped Resident #38 get up. The resident didn't like putting her arm into her shirt but she helped pull her arm through the shirt for her. Sometimes the resident wouldn't let her change her, but she would just ask her and Resident #38 allowed her to change her. Staff I reported she had not witnessed staff being rough or unkind to residents when she had worked, but if she did, she would report it to the DON right away.</p> <p>During an interview 11/21/24 at 12:05 PM, Staff G, LPN, stated she would notify her supervisor or the Administrator immediately if she had a concern about abuse. Staff G reported she witnessed Resident #38 being combative when she first came to the facility, especially when staff changed her but otherwise she had not observed any behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview 11/21/24 at 1:04 PM, Staff A reported she took care of Resident #38 like she was her grandmother. Staff A stated she talked to Resident #38 and asked her why she didn't smile. She tried to make her smile. She treated residents like they were her own parents. Staff A confirmed she had not witnessed staff being rough toward other residents. Staff A stated staff don't like her. She came to work and did her job. Staff A reported some staff wanted to take 5-6 breaks a shift, or took an hour break, then she didn't get a break. She was left to do the work. Staff A reported she talked to the Administrator about not getting a break because the other CNA's took an hour break. She reported it the week before they accused her of this incident. After she reported her concern, the facility suspended her. Staff A denied saying to a resident: if you punch me I will punch you, if you pinch me, I will pinch you. Staff A reported Resident #38 required assistance of two staff. The resident held Staff A's arm as she helped turn the resident. The resident's nails were sharp. Staff A reported Resident #38 doesn't talk, nor did she abuse or fight staff. Staff A acknowledged she had not worked at the facility since 10/23/24.</p> <p>In an interview 11/21/24 at 1:55 PM, the DON reported she had worked at the facility since 6/15/24. The DON reported Staff B came to the DON's office on 10/23 and told her Staff A handled Resident #38 in a rough way, and told her she would punch or pinch her. The DON reported she spoke with Resident #38. The resident shook her head yes when she asked her if someone had been rough with her. The resident said she felt safe though. The DON reported she talked to the Administrator. Staff B was suspended because she needed to report the incident when it happened. Staff A was also suspended. The DON reported Staff A had good rapport with residents when she worked her, so she was surprised by the statement from Staff B. The DON stated she had observed Staff A during a pericare audit, but otherwise she had observed Staff A perform cares on a resident. The DON reported the Unit Manager obtained a statement from Staff A. Staff education provided on abuse and neglect and that concerns for abuse needed to be reported right away to the Administrator or DON. Abuse education provided at the time of hire and as needed.</p> <p>During an interview 11/21/24 at 2:25 PM, the Unit Manager reported she had worked at the facility since 11/26/23. The unit manager acknowledged she had watched Staff A do cares and had not witnessed her coming across as rough. Staff A was good with residents and had good interactions. Nothing that made her step back and think she needed to do re-education. The unit manager reported she was not called on the day of the incident in 8/2024, but she thought she read something in Resident #38's progress note. The unit manager reported she was out of the building during the week of the state fair, and off for 10 days. If something such as a note was put in her mailbox she would not have gotten it until she came back to work 10 days later.</p> <p>In an interview on 11/21/24 at 4:03 PM. Staff J, LPN, reported she had worked at the facility since 4/18/24, and worked the 6 PM to 6 AM shift. Staff J confirmed she had taken the mandatory reporter abuse training and received information about abuse in meetings. Staff J acknowledged she had not witnessed any staff being unkind or rough, but she would report to the DON or on-call manager right away if she did. Staff J reported Resident #38 sometimes resisted care. She tells the resident they are there to help her, or she will leave and go back and help her. Resident # 38 liked staff to hold her hand. Her legs were stiff and it could be hard to move her. Staff J stated she always helped the aide when they asked. The CNA did not tell her about the incident with Resident #38 and a CNA. Staff J stated a couple of residents had concerns about a certain staff person taking care of them. When a resident voiced a concern, she switched out the assignment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 11/25/24 at 10:00 AM while reviewing the facility's removal plan, it was discovered a report was made by Resident #28 that a staff person was unkind to her.</p> <p>On 11/25/24 at 10:13 AM, the surveyor advised the Regional Director of Operations an issue where Resident # 28 had reported staff being unkind. The concern was noted during interview for the IJ F600 and F 609. The surveyor inquired if a report made to DIAL. The Regional Director of Operations confirmed no report made to DIAL, no follow up on the allegation completed, and the concern had not been investigated by the facility. The Regional Director of Operations brought paperwork back to the surveyors and informed them that it would be reported at that time because it had not been reported to DIAL yet. She was reminded that it would not be possible to remove the IJ until all potential abuse issues have been reported to the state agency.</p> <p>The facility made an allegation of abuse report to DIAL on 11/25/2024 at 10:31 AM regarding Resident # 28. The incident occurred on 11/22/24. Resident #28 reported during the interview that a staff member stated they did not have time for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on record review, staff interviews and facility policy review the facility failed to accurately complete 1 of 30 resident's (Resident #47) MDS assessment tools. The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>According to the Discharge Return Not Anticipated Minimum Data Set (MDS) assessment tool with a reference date of 8/23/24. The MDS documented Resident #47 was admitted to the facility on [DATE] from a short-term general hospital. The MDS indicated he was discharged from the facility on 8/23/24 to a short-term general hospital.</p> <p>The Care Plan focus area with an initiation date of 8/12/24 documented Resident #47 wished to returned to prior living arrangement at his group home.</p> <p>Review of a document titled Discharge Plan, Instructions and Summary dated 8/21/24 with a lock date of 9/3/24, documented Resident #47's goals of care and treatment preferences were to return to group managed facility. Resident #47 was discharged on [DATE] to a waiver-based housing with home health.</p> <p>Review of a document titled Notice of Transfer Form to Long Term Care Ombudsman, documented Resident #47 had a transfer date of 8/23/24 and was discharged home.</p> <p>On 11/21/24 at 3:23 PM the [NAME] President of Clinical Services indicated she signs off on the MDS assessments. When asked why Resident #47's discharge MDS documented he was sent to the hospital but his discharge summary documented he went to a waiver-based housing. She looked at the discharge MDS assessment and discharge summary, verified the MDS had documented he was sent to the hospital. She was unsure why it was documented like that and thought maybe the Social Worker that had completed the section clicked on the wrong option.</p> <p>On 11/21/24 at 3:30 PM the Social Worker acknowledged Resident #47 was not discharged to the hospital and may have marked that he did because that was where he was admitted from. The Social Worker acknowledged he should have documented Resident #47 was discharged to a community setting on his discharge MDS.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.</p> <p>49990</p> <p>Based on clinical record review, facility policy, and staff interview, the facility failed to submit a new preadmission screening and resident review (PASRR) level 1 screening as required for 1 of 20 residents screened (Resident #32). The facility reported a census of 49.</p> <p>Findings include:</p> <p>The Annual Minimum data set (MDS) for Resident #32, dated 08/02/2024, documented a brief interview for mental status score (BIMS) score of 11, indicating moderate cognitive impairment. It recorded the following relevant diagnoses: stroke, non-Alzheimer's dementia, hemiparesis, seizure disorder, depression, and psychotic disorder.</p> <p>The Care Plan for Resident #32, last revised 11/14/2024, documented a delusional disorder and the antipsychotic and antidepressant therapy currently used by the resident to manage symptoms.</p> <p>The Medication Administration Record (MAR), dated 11/2024, documented use of Olanzapine, an antipsychotic, every day in the month. It further documented the use of Venlafaxine, a selective Serotonin and Norepinephrine Reuptake Inhibitor (SNRI) used to treat depression, every day in the month.</p> <p>Review of the original PASRR level 1 screening, dated 08/12/2022, did not document a delusional or psychotic disorder, and while it documented mood disturbance it did not document depression or a seizure disorder. It documented the current treatment as Olanzapine, an antipsychotic. The PASRR states No further level 1 screening is required unless you are known to have or are suspected of having a serious mental illness or an intellectual disability or developmental disability or exhibit a significant change in treatment needs.</p> <p>In an email received on 11/21/2024, at 02:38 PM from Staff Q, Regional Nurse Consultant, she stated the facility did not have an updated PASRR. She further noted she had resubmitted.</p> <p>In an interview on 11/26/24 at 11:19 AM with the Social Worker, he stated the change in both treatment and diagnosis for Resident #32 required a resubmission of the level 1 PASRR screening. He stated Resident #32 underwent a period of abrupt changes and the resubmission was overlooked as they reevaluated the resident.</p> <p>Review of a facility provided document titled Admission Criteria, last revised in March of 2019, it documented all new admissions and readmissions are screened for mental disorders, intellectual disabilities, or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASRR) process. It further documented the facility social worker is responsible for making the referral to the state appointed authority.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34817</p> <p>Based on observations, staff interviews, and policy review, the facility failed to ensure a homelike environment and reduce clutter in the hallway for 2 or 2 units (North and South Halls). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>Observations revealed the following:</p> <p>a. On 11/19/24 at 10:45 AM, the North hall had equipment parked in the hallway by the handrails including a mechanical lift, a shower chair, a stand mechanical lift, a plastic bin with drawers containing Personal Protective Equipment (PPE), carts for trash and soiled laundry, two medication carts, a treatment cart, and a wheelchair. At the same time, the North/Central hall had equipment parked along the hallway and handrails including a mechanical lift, a stand mechanical lift, and a large motorized wheelchair.</p> <p>At 10:55 AM, the staff on the North hall had to move to the side of the hallway in order to allow a male resident to propel his wheelchair down the hall to his room.</p> <p>At 12:45 PM, a wheelchair sat by the exit door in the North hall. The North hall had a stand mechanical lift, a plastic bin with drawers with PPE inside, trash cart and soiled laundry carts, two medication carts, and a treatment cart parked along the hallway and handrails. The North/Central hall had a wheeled cart with a cooler on it, a mechanical lift, a medication cart, a cart with food trays, a stand mechanical lift, and a large motorized wheelchair parked in the hallway by the handrail.</p> <p>At 12:55 PM, Resident #22 sat in a wheelchair and yelled I told you to quit following me. Resident #3 sat in a motorized wheelchair heading in the opposite direction of Resident #22 but unable to get through due to the equipment parked in the hallways. The Administrator approached the residents and requested Resident #22 to backup so Resident #3 could get his wheelchair through.</p> <p>At 4:30 PM, a large bariatric sized wheelchair and another wheelchair sat by the North hall exit door. Equipment continued to line the hallway including a mechanical lift, a stand mechanical lift, trash and soiled laundry carts, two medication carts, a treatment cart, and a plastic bin with PPE inside.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. On 11/20/24 at 7:46 AM, the North hall had a medication cart, a treatment cart, soiled laundry and trash carts, a stand mechanical lift, and a mechanical lift parked along the handrail. A large bariatric wheelchair and a wheelchair were parked by the North Hall exit door. The North/Central hall had a mechanical lift, a medication cart, and a wheelchair parked along the handrail. At 9:14 AM, Resident # 22 wheeled herself in a wheelchair down the North/Central hallway toward the nurse's station as Resident #7 propelled his wheelchair down the same hallway in the opposite direction toward Resident #22. Resident #7 and Resident #22 hollered at each other regarding the need to move out of the way. The residents were unable to get through the hallway due to the equipment parked along the hallway at the time. Staff M, Licensed Practical Nurse (LPN), approached the residents to break up the argument and provided directive to Resident #22 to move over so Resident #7 could get through.</p> <p>c. On 11/19/24 at 11:41 AM. the South Hall was cluttered with equipment including two mechanical lifts, a medication cart, and several wheelchairs. The surveyor had to wait for a resident to pass through the hallway before the surveyor could proceed to walk down the hallway.</p> <p>d. On 11/20/24 at 7:16 AM, the South hall was cluttered with equipment, including two mechanical lifts, a medication cart, and two wheelchairs. One of the mechanical lifts had the stability legs open. As the surveyor pushed a bedside table down the hall, the bedside table clipped the side of the lift causing the surveyor to trip over the open mechanical lift leg.</p> <p>e. Observation on 11/21/24 at 6:00 PM, Staff B, certified nursing assistant (CNA) quickly pushed Resident #22 in a wheelchair without foot pedals on from the dining room down the hallway 40 feet as the resident's feet quickly shuffled along the floor.</p> <p>During an interview on 11/26/24 at 10:15 AM, the Regional Corporate Nurse Consultant reported the facility didn't have a policy for transporting residents in a wheelchair. She expected staff to follow the standards of practice with using wheelchair pedals whenever staff pushed a resident in the wheelchair.</p> <p>During an interview on 11/26/24 at 12:45 PM, the Regional Director of Operations reported the facility did not have a policy for equipment storage.</p> <p>A Homelike Environment policy revised 2/2021 revealed residents are provided with a safe, clean, comfortable and homelike environment. The characteristics of a clean and orderly environment reflected a personalized, homelike setting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>37074</p> <p>Based on record review, resident council notes, employee file review, staff and resident interviews and facility policy review the facility failed to answer call lights in a timely manner. The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>Review of the resident council minutes revealed the following notes:</p> <p>a) meeting date 8/29/24 at 2:00 PM documented 11 of the 11 residents that attended the meeting stated call light times are getting better, staff will continue with call light audits.</p> <p>b) meeting date 9/26/24 at 2:00 PM documented 6 of the 6 residents that attended the meeting stated call light times are getting better, staff will continue with call light audits.</p> <p>c) meeting date 10/23/24 at 2:00 PM documented 10-10 residents shared the concerns with call lights, staff will continue with call light audits.</p> <p>Review of Staff A's Certified Nursing Assistant (CNA) employee file revealed a disciplinary action form that documented seven call lights were on over 20 minutes on her assigned hall throughout the shift. The form was signed and dated by Staff A on 8/22/24. A document titled Past Calls on 8/21/24 documented the following call light response times: 23 minutes, 27 minutes, 26 minutes, 23 minutes, 21 minutes, 18 minutes, 19 minutes, 21 minutes, 28 minutes, 24 minutes, 18 minutes and 32 minutes. A second disciplinary action form documented extended call lights on her assigned hall on 10/14/24. They have discussed about extended call lights in the past as well. The form was signed and dated by Staff A on 10/15/24. A document titled Past Calls on 10/14/24 documented the following call light response times: 23 minutes, 31 minutes, 21 minutes, 22 minutes, 32 minutes, 39 minutes, 36 minutes, 19 minutes, 22 minutes, 19 minutes, 16 minutes, 35 minutes, 16 minutes, 17 minutes, 19 minutes, 46 minutes, and 37 minutes.</p> <p>Review of Staff B's CNA employee file revealed a disciplinary action record form dated 10/4/24 that stated see attached. The attached form titled Past Calls dated 10/2/24 documented the following call light response times: 28 minutes, 18 minutes, 59 minutes, 26 minutes, 1 hour and 54 minutes, 20 minutes, 22 minutes, 24 minutes, and 31 minutes.</p> <p>On 11/18/24 at 11:38 AM Resident # 202 reported it took staff at least 20 minutes to respond to her call light and provide assistance.</p> <p>On 11/19/24 at 8:12 AM Resident #10 reported sometimes it takes a while for them to come to clean me up, it makes me angry.</p> <p>On 11/19/24 at 9:06 AM Resident #40 stated that the weekends are horrible for staffing, they are very slow to answer the call lights on the weekends. She just doesn't feel they have enough staff, though it has been getting better.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility provided a policy titled Answer the Call Light, with a revision date of September 2022, documented the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Staff are to answer the resident call system timely.</p> <p>34817</p> <p>2. A Past Calls report dated 9/20/24 to 11/19/24 revealed call light response greater than 15 minutes for the following:</p> <p>a. Room North (N) 10:</p> <p>9/20 - 9/30/24: 16 times, with the longest response time 2 hours and 33 minutes</p> <p>10/1 - 10/31/24: 35 times, with the longest response time 2 hours and 12 minutes</p> <p>11/1 - 11/18/24: 5 times, with the longest response time 33 minutes</p> <p>The majority of call light response times greater than 15 minutes occurred on the evening (2 PM - 10 PM) and night (10 PM - 6 AM) shifts.</p> <p>b. Room N20</p> <p>9/20 -9/30/24: 6 times with the longest response time 2 hours and 17 minutes</p> <p>10/1 - 10/31/24: 42 times with the longest response time 3 hours and 3 minutes</p> <p>11/1 - 11/18/24: 17 times with the longest response time 1 hour and 1 minute.</p> <p>The majority of call light response times greater than 15 minutes occurred on the night (10 PM - 6 AM) and evening (2 PM - 10 PM) shifts.</p> <p>During an interview 11/26/24 at 8:40 AM, the Regional Director of Operations reported call light response times were part of the facility's Quality Assurance Performance Improvement (QAPI) process. The Regional Director of Operations reported the call light report was reviewed daily. Residents and staff are interviewed about any extended call light times to determine what happened. She wrote a note on the call light report about why staff response time was greater than 15 minutes. The Regional Director of Operations stated staff sometimes forgot to turn the call light off. The Regional Director of Operations explained in 9/2024, the average call light response that was greater than 15 minutes was 12 %, but now the response times were 10-11%. This didn't quantify how long call lights were on, but it gave her a metric to look at. She had seen significant improvement in call light response since 3/2024. The call light policy included an expectation for call lights answered within a reasonable timeframe. The benchmark was for staff to respond to call lights within 15 minutes but sometimes a resident required more than 15 minutes of care from staff.</p> <p>During an interview 11/26/24 at 9:30 AM, the Regional Director reported staff provided education about reasonable timeframes on call lights, and staff disciplinary done whenever they had concerns about call light response times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Answering the Call Light policy revised 9/2022 revealed call lights answered timely.</p> <p>The Facility Assessment updated 8/8/2024 revealed the facility made a good faith effort to ensure sufficient staffing to meet the needs of residents at any given time based on the resident population and their needs. The facility retained enough staff to maintain a 24-hour licensed facility 7 days a week. The day and evening shifts staffed with 2 nurses and 6 aides, and the overnight shift staffed with 2 nurses and 3 aides.</p> <p>49990</p> <p>3. A Past Calls report dated 9/20/24 to 11/19/24 revealed call light response greater than 15 minutes for the following:</p> <p>a. Room Central (C) 4:</p> <p>09/20-09/30/2024: 6 times. With the longest call light on 09/29/2024 being 1 hour 48 minutes and 17 seconds.</p> <p>10/01-10/31/2024: 11 times. With the longest call light on 10/17/2024 being 1 hour 15 minutes and 48 seconds.</p> <p>11/01-11/18/2024: 2 times. With the longest call light on 11/12/2024 being 37 minutes and 29 seconds.</p> <p>b. Room North (N) 5:</p> <p>09/20-09/30/2024: 0 Times.</p> <p>10/01-10/31/2024: 3 times. With the longest call light on 10/09/2024 being 24 minutes and 24 seconds.</p> <p>11/01-11/18/2024: 5 times. With the longest call light on 11/14/2024 being 39 minutes and 34 seconds.</p> <p>c. Room South (S) 18:</p> <p>09/20-09/30/2024: 6 times. With the longest call light on 09/23/2024 being 48 minutes and 32 seconds.</p> <p>10/01-10/31/2024: 27 times. With the longest call light on 10/12/2024 being 38 minutes and 46 seconds.</p> <p>11/01-11/18/2024: 10 times. With the longest call light on 11/12/2024 being 31 minutes and 11 seconds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/26/24 at 11:48 AM with the Director of Nursing (DON), she stated it is her expectation that call lights are answered in a reasonable time frame. When asked directly what she felt was a reasonable time frame meant, she stated it means as fast as possible, then clarified the expectation is within 15 minutes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>49990</p> <p>Based on clinical record review, staff interview, and facility policy review, the facility failed to track and document behaviors for residents taking psychiatric medication for 3 of 3 residents screened (Resident #32, #11, and #24). The facility reported a census of 49.</p> <p>Findings include:</p> <p>1. The Annual Minimum data set (MDS) for Resident #32, dated 08/02/2024, documented a brief interview for mental status score (BIMS) score of 11, indicating moderate cognitive impairment. It recorded the following relevant diagnoses: stroke, non-Alzheimer's dementia, hemiparesis, seizure disorder, depression, and psychotic disorder.</p> <p>The Care Plan for Resident #32, last revised 11/14/2024, documented the resident had alterations in mood and behavioral symptoms and was receiving antipsychotic and antidepressant therapy to manage symptoms. It directed staff to attempt non-drug approaches to redirect behavior as appropriate, but did not document what behaviors the resident had nor what non-drug approaches should be used.</p> <p>Review of the Medication Administration Record (MAR), dated 11/2024, documented the following medications; olanzapine 2.5mg once per day, and venlafaxine 75mg once per day. It also documented behaviors occurred on the following dates:</p> <p>11/01/2024</p> <p>11/03/2024</p> <p>11/05/2024</p> <p>11/07/2024</p> <p>11/08/2024</p> <p>11/09/2024</p> <p>11/10/2024</p> <p>11/11/2024</p> <p>11/12/2024</p> <p>It did not document what behaviors were occurring at these times.</p> <p>Review of nursing progress notes dated from 11/01/2024 to 11/26/2024 document behaviors were observed on:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>11/02/2024</p> <p>11/04/2024</p> <p>11/05/2024</p> <p>11/08/2024</p> <p>11/10/2024</p> <p>11/11/2024</p> <p>11/12/2024</p> <p>11/14/2024</p> <p>11/16/2024</p> <p>11/17/2024</p> <p>11/18/2024</p> <p>11/19/2024</p> <p>11/21/2024</p> <p>11/23/2024</p> <p>11/25/2024</p> <p>The progress notes did not document what behaviors were observed.</p> <p>Review of the electronic health record (EHR) behavioral monitoring and interventions sheet for Resident #32, dated from 11/01/2024 through 11/26/2024 documented No Behaviors observed for all dates. This finding is discrepant from the MAR and Nursing Progress notes.</p> <p>2. The Quarterly MDS for Resident #11, dated 11/01/2024, documented a BIMS score of 12, indicating moderate cognitive impairment. It documented the following relevant diagnoses, Non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, and schizophrenia.</p> <p>The Care Plan for Resident #11, last revised on 11/14/2024, revealed the resident had specialized psychiatric services with medication management that included psychotropic medication. It directed staff to attempt non-drug approaches as appropriate, but did not document what non-drug approaches to attempt.</p> <p>The MAR, dated 11/2024, documented the following medications; Clonazepam 1mg tablet once a day, olanzapine 10mg once a day, Sertraline 75mg once a day, Clonazepam .5mg twice a day. It contained non-pharmacological interventions for pain management, but not for management of behavioral issues.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress notes dated 11/01/2024 to 11/26/2024 documented no behaviors occurred during the lookback period.</p> <p>Review of the EHR documentation titled Behavior monitoring and interventions lacked documentation for all days in the 30 day lookback period except for 11/20/2024, where it documented no behaviors observed.</p> <p>3. The Annual MDS for Resident #24, dated 08/29/2024, documented a BIMS score of 13, indicating intact cognition. It further documented relevant diagnoses of; stroke, Non-Alzheimer's dementia, anxiety disorder, and depression.</p> <p>The Care Plan for Resident #24, last revised on 11/19/2024, documented the resident received psychotropic medication therapy. It documented manipulative behavior as a behavior to watch for. It further advised the reader to attempt non-drug interventions but did not document what non-drug interventions to attempt.</p> <p>The MAR, dated 11/2024, documented the following medications; Duloxetine sprinkles 60mg twice per day (for treatment of anxiety, and depression), Levetiracetam 750mg twice per day (treatment for seizures), Buspirone 10mg three times per day, Buspirone 5mg three times per day (treatment for anxiety). It documented behaviors to watch for as anxiousness, tearfulness, self isolation, It documented anxious behaviors on one day, 11/09/2024.</p> <p>The Nursing Progress Notes, dated 11/01/2024 through 11/26/2024, documented behaviors on the following days;</p> <p>11/02/2024</p> <p>11/04/2024</p> <p>11/06/2024</p> <p>11/07/2024</p> <p>11/08/2024</p> <p>11/09/2024</p> <p>11/10/2024</p> <p>11/11/2024</p> <p>11/13/2024</p> <p>11/14/2024</p> <p>11/16/2024</p> <p>11/17/2024</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/18/2024</p> <p>11/19/2024</p> <p>11/21/2024</p> <p>11/22/2024</p> <p>11/23/2024</p> <p>11/25/2024</p> <p>It only contained specific behaviors on 11/22/2024, where it was documented the resident was experiencing hallucinations.</p> <p>The EHR behavior symptoms monitoring page contained no documentation of any kind within the 30 day lookback period. This finding is discrepant from the nursing progress notes.</p> <p>In an interview on 11/21/24 at 10:30 AM with Staff S, Certified Nurses Aide, she stated she was unaware that Resident #11, #24, and #32 had behaviors she should be monitoring. She stated behavior tracking is done in the electronic health record, and they are also to report any behaviors to the nurse on call who is responsible for putting in a nursing progress note.</p> <p>In an interview on 11/21/24 at 10:12 with Staff T, CNA, she stated she was not as familiar with resident #24, but was familiar with Resident #11 and #32. She stated residents have their behaviors listed in the electronic health record, and when they observe behaviors they are required to document them in the EHR and report the behaviors to the nurse. She was unaware that Resident #11 and Resident #32 had behaviors.</p> <p>In an interview on 11/26/24 at 11:48 AM with the Director of Nursing (DON) she stated behaviors are tracked in the electronic health record, and specific behaviors to watch for are documented in the EHR. Her expectation is for the behavioral documentation task to be performed every shift for residents who have the task.</p> <p>The facility did not provide policies for behavioral tracking .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990</p> <p>Based on clinical record review, observation, staff interview and manufacturer's instructions, the facility failed to administer insulin flexpen to ensure the proper amount of insulin administered for one resident observed who received insulin during medication pass (Resident #28). The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a diagnosis of Diabetes Mellitus, and had received insulin injections seven of the seven days during the lookback period.</p> <p>The Medication administration record (MAR) dated 11/01/24 through 11/30/24 revealed insulin Lispro subcutaneous solution 8 units injected subcutaneously three times a day.</p> <p>During an observation on 11/20/24 at 01:14 PM, Staff P, Licensed Practical Nurse (LPN), prepared to administer the Lispro pen-injector to Resident #28. She was observed taking the medication out of the box, checking the MAR, and then administering the medication to Resident #28. She was not observed to have performed hand hygiene before preparing to administer the medication. She was not observed to prime the pen and then purge 2 units of insulin, ensuring the pen was in working order. During the administration of the medication, she held the pen to the skin for just two and a half seconds, and was not observed to check the pen to ensure all insulin had been administered.</p> <p>During the observation on 11/20/24 at 01:14 PM, the surveyor asked Staff P, LPN, if she had primed the pen before administering insulin. She stated she had already done so.</p> <p>In an interview on 11/20/24 at 01:56 PM with Staff Q, Regional Corporate Nurse Consultant, she stated she had not seen Staff P wash or sanitize her hands before administering the medication. She was unsure if Staff P had primed the insulin pen, as she did not see. She did not see Staff P check the insulin pen to ensure all units of insulin had been administered. She was unsure how long the nurse should have held the insulin pen to the arm to ensure complete administration of the medication.</p> <p>In an interview on 11/26/24 at 11:48 AM with the Director of Nursing (DON), she stated her expectation is for staff members to hold insulin pens to the skin for a minimum of five seconds, though she advised staff members to hold for ten seconds as a matter of best practice. She stated some pens recommend more than five seconds. She stated her expectation is for nurses to abide by manufacturer recommendations when using insulin pens, which typically includes the priming and purging of two units of insulin to ensure the pen is in proper working order, and for nurses to always check the pen after administration to ensure the pen functioned properly and administered the full dose of medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/26/24 at 02:14 PM with Staff R, Licensed Pharmacist, she stated the Lispro Pen injector requires the priming and purging of two units of insulin to ensure the pen is functioning as intended. It ensures the resident gets the full dose of medication. You should also hold the pen to the skin for at least 5 seconds, the Lispro Pen injector manufacturer's guidelines state 5 seconds at minimum, but she stated best practice is 10 seconds. Failure to perform these two steps could result in the resident not having received the full dose of medication as ordered and could have negative health outcomes associated with high blood sugars.</p> <p>Review of the Lispro pen injector manufacturer's insert, last revised in July of 2023, documented the following steps to ensure safe and effective usage of the Lispro Kwikpen Injector System:</p> <p>Step 6: To Prime your Pen, turn the Dose Knob to select 2 units. - It advised users that failure to perform this step may cause the recipient to receive too much or too little medicine.</p> <p>Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge holder gently to collect air bubbles at the top.</p> <p>Step 8: Continue holding your pen with needle pointing up. Push the dose knob until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. - It advised the user that if they should not see insulin at the tip of the needle they should priming steps 6-8 no more than four times.</p> <p>Step 11: Insert the needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. - A diagram on the same page suggested a 5 second hold to the skin.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37074</p> <p>Based on observations, staff interviews and facility policy review the facility failed to store and serve food in a sanitary manner. The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. Observation of dinner service on 11/20/24 at 5:20 PM revealed Staff C [NAME] was serving dinner in the dining room. Staff C placed tin pans in the steam table then licked her right index finger. Staff C continued with food service without washing her hands after licking her finger. At 5:45 PM in between plating resident's food, Staff C placed her right hand on her mouth, touching her lips with her finger tips and hand. Staff C continued with dinner service without washing her hands.</p> <p>On 11/21/24 at 1:00 PM Staff D Dietary Aide and Staff E [NAME] were in the kitchen. Staff E had a hair net up with his long hair hanging out the bottom of the hair net, resting on his shoulders. Staff D had his hair in braids and pulled back in a pony tail with the hair net only covering the hair in the pony tail. The hair net was not covering his hair his pony tail at the center of the back of his head to his hair line.</p> <p>34817</p> <p>2. Initial tour of the kitchen on 11/18/24 starting at 9:35 AM, revealed the following:</p> <p>a. The hallway by the ice machine and outside of the kitchen had dried leaves and dirt on the floor.</p> <p>b. The dry storage area had a brown stained ceiling tile that bulged down over cereal stored on shelves.</p> <p>c. The Troulsen refrigerator had unlabeled and undated items including:</p> <p>One square container of orange-colored juice</p> <p>Three carafes filled with a clear beverage</p> <p>One pitcher of red juice</p> <p>One pitcher of yellow colored juice</p> <p>d. The Avantco refrigerator cooler had no thermometer inside. The cooler contained an open gallon of 2 % white milk and an open gallon of 2% chocolate milk but had no open date listed. One gallon of white milk had a brown sticky substance over the cap and container. The bottom of the cooler had a brown, sticky substance.</p> <p>e. The Troulsen freezer had:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>One unlabeled and undated container of diced chicken.</p> <p>One opened box of chicken tenderloins (open date 11/14) exposed to air.</p> <p>f. The Frigidaire refrigerator had a broken thermometer and contained unlabeled and undated food:</p> <p>One container of green beans</p> <p>One container with ham slices</p> <p>g. A bulk container of sugar had a handled scoop immersed in the sugar.</p> <p>h. A bulk container labeled thickener had a plastic container lying in the thickener</p> <p>i. A large fan sat on a black cart facing toward the clean dishes and food prep counter. The fan had a buildup of gray, dusty debris.</p> <p>j. On 11/26/24 at 8:15 AM, the Frigidaire refrigerator and milk coolers had a working thermometer inside. The Frigidaire refrigerator had an unlabeled and undated container of boiled eggs.</p> <p>On 11/18/24 at 9:45 AM, Staff C, dietary cook, attempted to locate the thermometer in the milk cooler. Staff C moved the milk crates in the milk cooler but reported no thermometer found.</p> <p>In an interview 11/18/24 at 10:17 AM, the Administrator reported the current Dietary Manager only worked PRN (as needed), but still supported the building with ordering things.</p> <p>In an interview 11/26/24 at 12:00 PM, the Dietician reported she came to the facility on ce a week, typically on Tuesdays. The dietician reported all foods needed to be labeled including the open date, the use by date, and the initials of the staff person. Fruit entrees should be discarded within 7 days if not used. Scoops for the bulk storage should be stored in a holder on the exterior of the storage bin. The dietician reported the dietary staff had a daily cleaning schedule that included wiping down areas and sweeping the floors. Any juice spillage needed wiped up as soon as possible. The cook on duty was responsible to ensure cleaning completed before staff left at the end of the shift. The dietician reported she didn't know who cleaned the fan in the kitchen, but maintenance staff cleaned and maintained some areas in the kitchen. The dietician reported she expected staff wore gloves whenever they handled ready to eat food, including buttering bread or dinner rolls. Gloves should be changed between tasks.</p> <p>A Refrigerators and Freezers policy revised 11/2022 revealed the facility ensured safe refrigeration and freezer maintenance, temperatures and sanitization, and observed food expiration guidelines. Food kept at or below 41 degrees Fahrenheit (F) in the refrigerator. All foods dated to ensure proper rotation by expiration dates. Use by dates are completed on all prepared food in the refrigerators, and a use by indicated whenever food opened. Foods stored according to the Food Receiving and Storage policy. The supervisors are responsible for ensuring food items are not past the use by of expiration dates, as well as inspection of needed maintenance. Refrigerators and freezers are kept clean, free of debris, and disinfected as necessary.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A Food Receiving and Storage policy revised 10/2017 revealed all foods stored in the refrigerator or freezer need to be covered, labeled, and dated (use by date). Frozen food wrappers must stay intact until thawing. Beverages must be dated when opened and discarded after 24 hours. Open containers must be dated when opened and sealed or covered during storage.</p> <p>A Sanitization policy revised 11/2022 revealed the food service area is maintained in a clean and sanitary manner. All utensils and equipment kept clean, maintained in good repair and free from break or cracks that may affect their use of proper cleaning.</p> <p>A Food Preparation and Service policy revised 4/2019 revealed food prepared and served in a manner that complies with safe food handling practices. Staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Bare hand contact with food is prohibited. Gloves worn whenever food handled directly and changed between tasks.</p> <p>A Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy revised 11/2022 revealed appropriate hygiene and sanitary procedures followed to prevent the spread of foodborne illness. Employees must wash their hands during food preparation as often as necessary to prevent cross contamination when changing tasks or after engaging in other activities that contaminated their hands. Hair restraints such as hairnet, beard restraint worn when preparing or assembling food to keep hair from contacting exposed food, utensils, and equipment.</p> <p>49990</p> <p>3. Subsequent walkthrough on 11/21/24 at 02:22 PM of the kitchen revealed Staff E, dietary cook, was observed wearing a hair net covering the pony tail of his hair, but did not cover hair on the top of his hair. Staff E was also not seen wearing a beard net.</p> <p>The walkthrough further revealed a white commercial preparation refrigerator contained a thermometer which was visibly damaged, with a crack dividing the thermometer in two. It was partially functional, but documented a temperature of 48 degrees. Also contained within the preparation refrigerator were three individual servings of a brown sauce Staff E identified as barbeque sauce. It was unlabeled, and had a desiccated appearance. Staff E was unsure when they had been prepared, but stated he believed it had been from a dinner service the week of the survey.</p> <p>Inspection of an industrial standup freezer in the dry storage area of the kitchen revealed a sealed container of unlabeled white meat which Staff E identified as turkey breast. He believed it was last used earlier in the day, but did not know when it was opened.</p> <p>Inspection of an industrial standup refrigerator in the dry storage area revealed a container of strawberries in syrup with an open date of 10/30/24. The container was visibly bulging, with a rounded top and bottom that prevented the container from standing flat in the cooler. Upon opening the container, pressure was released and a foul, alcoholic smell permeated the air. Visual inspection of the strawberries showed black and green growth, and the mixture was visibly bubbling as if it had been carbonated. Staff E said that it was rotten and that he knew it needed to be thrown away. He further stated the container had been opened nearly a month ago. He stated protocol was to dispose of products like the strawberries five to seven days after opening.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Azria Health Park Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 East Eighth Street Des Moines, IA 50316	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A direct observation on 11/18/24 at 12:16 PM revealed Staff X, Certified Nursed Aide (CNA), serving meals to residents with her thumb on the inside of the pudding bowls on multiple occasions.</p> <p>A direct observation on 11/18/24 at 12:18 PM revealed Staff T, CNA, serving meals to residents with her thumb on the inside of the bowls used to serve pudding.</p> <p>A direct observation on 11/18/24 at 12:23 PM showed Staff X, CNA, grabbed a residents dinner roll with bare hands, tore it open for them, and buttered and jellied the roll.</p> <p>A direct observation on 11/18/24 at 12:24 PM revealed Staff L, CNA, used her bare hands to grab, open, and apply butter and jelly to a residents dinner roll.</p> <p>In an interview on 11/26/24 at 12:02 PM with the Registered dietician, she stated fruits preserved in sugar, such as the strawberries in syrup, should be discarded seven days after opening. She agreed staff members are never to directly touch a residents food or place their fingers on eating surfaces such as the inside of a bowl without gloves and hand sanitation.</p> <p>In an interview on 11/26/24 at 11:48 AM with the Director of Nursing (DON), she agreed staff members should never have direct contact with a residents food without fresh gloves and hand sanitation.</p>